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The Effects of Medicaid Reimbursement Rates on Access to Dental Care

Dentists cite three primary reasons for their low participation in state Medicaid programs: low reimbursement rates, burdensome administrative requirements, and problematic patient behaviors. In the late 1990s and early 2000s, a number of states took dramatic steps to try to improve access to dental care in Medicaid. Alabama, Michigan, South Carolina, Tennessee, Virginia, and Washington employed a variety of approaches to address access concerns. They raised reimbursement rates, revamped administrative structures and processes, and conducted outreach and education to both providers and patients. This study, sponsored by the California HealthCare Foundation, focuses on the efforts of these six states and compares their experiences to California's. The National Academy for State Health Policy (NASHP) conducted a literature review and 26 key informant interviews to answer the question: what effect does raising Medicaid reimbursement rates have on access to dental care? In the six states examined, provider participation increased by at least one- third, and sometimes more than doubled, following rate increases. The study found that rate increases that at least bring rates to a level where they meet the provider's overhead expenses are necessary – but are not sufficient on their own – to improve access to dental care. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also critical. Administrative streamlining and working closely with dentists can help maximize the benefit of smaller rate increases, and mitigate potential damage when state budgets contract.

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May 2006

Oral Health

Attachment	Size
CHCF_dental_rates.pdf	344.4 KB

Medicaid Health Care Workforce Oral Health All NASHP Reports

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Increasing Access to Medicaid Dental Services for Children Through Collaborative Partnerships

American Dental Association • March 2004

Reports produced on behalf of the U.S. Congress,[1,2] and Department of Health and Human Services[3] have affirmed that problems with access to dental care for children enrolled in Medicaid are chronic and pervasive. These reports, along with the proceedings of numerous national and state forums convened in recent years, generally *identify three serious areas of concern with dental Medicaid programs that discourage dentist participation and limit access to care:*

√ Inadequate financing and reimbursement;

√ Program administration features that dentists find unduly burdensome and different from dental benefit programs for their privately insured patients; and

√ Failure to provide for effective Medicaid outreach and care coordination services to improve beneficiary understanding about oral health and reduce missed appointments.

Several states have begun to examine these concerns closely and implement strategies for improvement. To highlight the various strategies being pursued and allow other states to learn from example, the ADA has captured various state innovations in the attached policy briefs. Additional information on state-specific innovations can also be found via the ADA website at http://www.prnewswire.com/mnr/ada/11207/.

What is not addressed in the briefs, but considered equally significant in the effort to improve state Medicaid programs is the importance of establishing a sustained collaboration and partnership between state Medicaid officials and dentists.

Rationale for Sustained Collaborations

Medicaid is governed by federal legislation and regulations; however within those parameters, states have considerable latitude to structure and administer the program. Designing and operating a program that conforms to established guidelines--which may change over time--and changes in dental care financing and delivery systems require ongoing education and interaction among the principal parties involved (program officials and dental providers).

Medicaid program officials and dentists often have very different perspectives about the factors that contribute to limited access to services for Medicaid beneficiaries and what constitutes appropriate dental benefits for children in Medicaid. Therefore, developing a mechanism to share and discuss respective viewpoints on a periodic, ongoing basis becomes an important, if not essential, precursor for creating a common foundation for designing and implementing program changes. Medicaid *dental program task forces, advisory committees* or *work groups* are frequently used for this purpose. Ongoing advisory group forums may be used to educate Medicaid officials and dental care providers about broader underlying issues and trends (e.g., health care financing, dental benefits administration, changes in the covered population), and also provide an opportunity to assess the pros and cons of approaches that have yielded Medicaid improvements in other states.

Moreover, because the environment in which Medicaid dental programs operate changes constantly, advisory groups can help develop recommendations on adapting the program in ways that consistently address program requirements and contemporary professional practice. Foremost among these 'environmental changes' are fluctuations in state budgets and variations in guidelines that affect patient eligibility for services. Regular communications also can help assess the long-term performance of a Medicaid dental program, evaluate the impact of significant program changes, and identify opportunities for ongoing program improvements.

Examples from Selected States

Several states have engaged in significant efforts to improve access to dental services for individuals covered by Medicaid. The following selected examples highlight the variety and importance of sustained collaboration among program officials and dental providers in those efforts.

Alabama

Faced with increasing Medicaid enrollments and declining provider participation, Alabama Medicaid officials sought to remedy what was viewed as a 'dental crisis' beginning in 1997. One of the first steps was to seek assistance from the dental provider community through the creation of a **Dental Task Force**. The task force determined the major issues surrounding the dental program; made recommendations concerning program administration, covered services and reimbursement levels; and subsequently worked to address these issues. Alabama Medicaid also formed an **Outreach Work Group** to recruit new Medicaid providers. Alabama subsequently was selected for participation in the National Governors Association (NGA) Oral Health Policy Academy, which allowed further development of a **state-level strategic plan and action plan** on dental access issues. These efforts were augmented by funding from the Robert Wood Johnson Foundation to increase the Medicaid dental provider base and educate the public about the importance of good oral health. The Dental Task Force continues to meet quarterly to monitor program performance and provide input on policy and program changes. Alabama also has held a series of **dental Medicaid summits** to sustain

attention to the issue and focus on ways to remove access barriers. More recently, an **Oral Health Coalition**, consisting of three workgroups, has been formed to:

- √ Assist the state in disseminating information and building public awareness;
- √ Advise in the development, implementation and completion of the strategic oral health plan; and
- √ Create and reinforce relationships between key stakeholders to ensure the success of state efforts in improving oral health care in Alabama.

These combined and sustained efforts have resulted in significant increases in provider participation and utilization of services by Medicaid enrollees in Alabama. In fiscal year (FY) 2002, approximately 50,000 more Alabama Medicaid-enrolled children received dental services than in FY 2000. Overall, FY 2002 utilization rates were three times the levels reported in FY 1998.

Delaware

Extremely low levels of Medicaid participation by private dentists spurred Delaware's Medicaid officials to develop a partnership with the provider community. Steps taken to address access issues included development of a **state access report** in 1997, followed by the formation of a **Dental Access Improvement Committee** in 1998. State officials and representatives of practicing dentists also participated in the development of a **state-level strategic plan and action plan** through the NGA Oral Health Policy Academy. These efforts culminated in significant program changes involving claims submission, a new Medicaid Provider Manual, implementation of an innovative approach for enhanced Medicaid dental reimbursement, and a dentist recruitment campaign organized by the state dental association. Results included the participation of more than 100 new dentist providers in Medicaid and a doubling of the number of children receiving dental services between FY 1998 and FY 2001.

Indiana, South Carolina and Georgia

Substantial Medicaid program changes in 1997 that were viewed as unduly burdensome by Indiana dentists resulted in an exodus of participating providers and a public outcry for efforts to restore access to services. A **Dental Advisory Panel** was formed to provide input on policy and payment issues. Prominent ensuing changes included a 'carve out' of dental benefits from Medicaid managed care and rate increases to the 75th percentile of prevailing market fees. Also notable is the involvement of practicing dentists in helping state officials review Medicaid dental expenditures and identify areas where program savings could be achieved without sacrificing essential benefits. Results included an increase of more than 50 percent in dentist participation in Medicaid and a tripling of the number of children receiving dental services between FY 1998 and FY 2001. Similar collaborative partnerships in South Carolina and Georgia have yielded

comparable results. In South Carolina and Georgia, the partnership also has been effective in stimulating provider recruitment - dental recruitment campaigns being organized by the state dental associations. In recent years, both states also have succeeded in preserving core program enhancements in the face of declining state revenues and growing Medicaid budget pressures.

Michigan

Michigan has implemented a highly successful alternative to its traditional state-administered Medicaid program that relies on contracting out dental Medicaid benefits under a popular commercial dental benefits plan administered by Delta Dental in 37 counties. The Healthy Kids Dental (HKD)[4] program began in 2000, although the state's effort to address Medicaid dental access issues began in 1995 with the development of a **Dental Medicaid Task Force**, and went on to include efforts to engage political support among key stakeholders both within and outside of dentistry, and strategic action involving the media, public and key legislators. Results include an increase of nearly 40 percent in utilization among continuously enrolled Medicaid children, substantial increases in dentists' participation, more comprehensive services to beneficiaries, and services being delivered closer to where enrolled children live.

Tennessee

Substantial revisions to Tennessee's Medicaid dental program in 2002 include 'carving out' dental benefits from the state's Medicaid managed care program and contracting with a single commercial vendor (Doral Dental) to administer dental Medicaid benefits under an arrangement that reimburses at the 75th percentile of market-based fees. Prominent steps leading up to this fundamental change include participation by key stakeholders in a 2000 NGA Oral Health Policy Academy, development of a comprehensive children's oral health plan, formation of a **Dental Advisory Committee**, and promotion of the new program by the Tennessee Dental Association. While the program is relatively new, it has already achieved substantial increases in dentist participation and utilization of services.

Conclusion

The examples noted above underscore the variety of strategies and the critical importance of sustained collaborative partnerships among state officials and the dental community aimed at achieving meaningful improvements in access to dental services for Medicaid enrollees. They provide important lessons about promising approaches related to benefits administration, financing and reimbursement, and outreach to providers and beneficiaries. At a more fundamental level, they highlight the potential improvements in access that can accrue from sustained, effective collaboration.

The initial draft of this brief was developed for the American Dental Association by James J. Crall, D.D.S., Sc.D. and Donald Schneider, D.D.S., M.P.H. through a consulting agreement. Subsequent review and final editing was conducted by the American Dental Association.

This brief was created to highlight the activities states have pursued in an effort to improve access to oral health care for children enrolled in Medicaid and/or the State Children's Health Insurance Program (SCHIP). The information outlined is based on publicly available materials and feedback from state officials, and does not contain opinions or judgments on the success or failure of any state activity or innovation. The ideas expressed herein are not necessarily those of, nor endorsed by the American Dental Association. To get additional data or information, the reader should consult with appropriate state officials.

[1] General Accounting Office (GAO). Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations; U.S. General Accounting Office. HEHS-00-72, April 2000.
[2] General Accounting Office (GAO). Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations; U.S. General Accounting Office. HEHS-00-149, September 2000.
[3] Office of the Inspector General (OIG), U.S. Department of Health and Human Services. Children's Dental Services Under Medicaid: Access and Utilization. San Francisco, CA: U.S. Department of Health and Human Services, 1996.
[4] For additional information on the Healthy Kids Dental program see Eklund et al., JADA 2003;134:1509-1515.